88-1659

Supreme Court, U.S.
FILED
APR 11 1989

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

APPENDIX TO
PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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THEODORE KANNE and
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Vol. II of II

APPENDIX A

APPENDIX A

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

THEODORE KANNE, and BEATRIZ KANNE, Plaintiffs, v CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a Connecticut corporation; THE LINCOLN NATIONAL LIFE INSURANCE COMPANY, an Indiana corporation; METROPOLITAN LIFE INSURANCE COMPANY, a New York corporation; HARLOW CARPETS INC. a California corporation; HART, SHAFFNER & MARX, a General Partnership; DOES 1 through 50, Inclusive, Defendants.	NO. CV 83-2261-ER AMENDED MEMORANDUM DECISION

This matter came on regularly for trial on March 6, 1984, before the Honorable Edward Rafeedie, United States District Judge. Plaintiffs Theodore Kanne and Beatriz Kanne appeared with their attorneys of record, Carol A. Hay and Ernest

Franceschi, Jr. Defendant Connecticut General Life Insurance Company appeared through its attorneys of record, Adams, Duque & Hazeltine, by James Cline and Suzette Clover. The Court, heard the testimony of witnesses, having received oral and documentary evidence in the matter and having considered the pleadings and all of the records and files herein, renders its decision as follows:

I. BACKGROUND

1. Procedural

On December 17, 1982 plaintiffs Theodore Kanne ("Theodore") and Beatriz Kanne ("Beatriz") filed this civil action in the Superior Court of the State of California for the County of Los Angeles. The defendants at that time were Connecticut General Life Insurance Company ("Connecticut General"), Lincoln National Life, Metropolitan Life Insurance Company ("Metropolitan"),

Harlow Carpets, Inc. ("Harlow Carpets") and Hart, Shaffner & Marx. The complaint sought compensatory and punitive damages under state law for (1) breach of contract by failing to pay claims for medical benefits within a reasonable period of time, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of fiduciary duties, (4) common law fraud, and (5) breach of statutory duties under California Insurance Code § 790.03.

Connecticut General and Metropolitan answered the complaint on March 18, 1983. In their answer, they denied plaintiffs' allegations and raised affirmative defenses, including failure to state a claim for relief as to all causes of action, full payment of benefits due, privilege to assert one's rights in good faith, the bars of California Insurance Code § 10111 and Civil Code § 3302, failure to mitigate

damages, preemption by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001-1381, ("ERISA"), failure to exhaust administrative remedies under ERISA, and the unconstitutionality of allowing punitive damages against the defendant for breach of the covenant of good faith and fair dealing.

On February 4, 1983, plaintiffs filed a Motion to Remand. The Court granted the motion on March 24, 1983. After the parties stipulated to the dismissal of Lincoln National Life Insurance Company and Harlow Carpets on March 3, 1983, the action again was removed to federal court on April 8, 1983 on the basis of diversity jurisdiction. On April 19, 1983, Hart, Shaffner & Marx filed a Motion to Dismiss Extra-Contractual Claims, which the Court granted on May 23, 1983. On April 13, 1983, Metropolitan filed a Motion for Summary Judgment, which the Court granted on June 17, 1983. Although

plaintiffs appealed these determinations, they subsequently dismissed their appeals. Finally, upon reaching a settlement with Hart, Shaffner & Marx on November 1, 1983, plaintiffs requested that Hart, Shaffner & Marx be dismissed with prejudice. The Court granted this request.

2. Factual

On May 23, 1981, Theodore was an employee of Harlow Carpets. Since Connecticut General had issued a group medical insurance policy (the "policy") to the ABC Trust, of which Harlow Carpets was a member, Theodore was covered as an eligible employee under the policy. The ABC Trust is administered by the Associated Builders and Contractors in Washington, D.C. Similarly, on the same date, Beatriz was covered as an eligible employee under a self-funded ERISA plan at her place of employment, Hart, Shaffner & Marx. This plan was

administered by Metropolitan Life Insurance Company.[1/]

Jonathan Kanne ("Jonathan") was born on May 23, 1981 to Theodore and Beatriz while they were vacationing in Holland. Although the policy provided primary coverage for Jonathan only from the date of application by his parents, ABC Trust later authorized coverage retroactive to May 23, 1981. The Hart, Shaffner & Marx policy provided Jonathan with secondary coverage from May 23, 1981 through January 31, 1982.

Jonathan was born two months early with congestive heart failure. Within two weeks he was diagnosed as being cyanotic (a "blue baby") as a result of the heart failure. Shortly thereafter, Theodore provided this information to Connecticut General.

Doctors in Holland subsequently recommended that Jonathan be treated at Moffitt Hospital in San Francisco. Theodore advised

Metropolitan of this recommendation and requested an advance payment for air transportation fees on KLM, Royal Dutch Airlines, in the sum of $3,000.00 This amount was to cover first class airfare for Beatriz and Jonathan, oxygen for Jonathan while in first class, and modification of the plane's electrical system necessitated by Jonathan's need for oxygen.

Because Connecticut General and Metropolitan refused to advance any portion of the requested sums, Theodore drove to Mexico to borrow the necessary money from his father. Jonathan thereafter was transported from Amsterdam to Los Angeles by KLM Airlines and from Los Angeles to San Francisco by Schaffer Air Ambulance.

After Jonathan arrived in San Francisco, Theodore obtained reimbursement in the sum of $698.40 from Metropolitan. Theodore then sought to recover the balance from

Connecticut General under a coordination of benefits arrangement between the two insurance companies.

The Kannes dealt with Rosa Monostroi ("Rosa"), the Connecticut General Senior Benefits Analyst with primary responsibility for handling claims of the ABC Trust involving employees and dependents of Harlow Carpets. Rosa initially rejected the KLM claim on the ground that San Francisco was not the nearest hospital to Amsterdam. Thereafter, she changed her reasoning, determining instead that the treatment Jonathan was to receive in San Francisco was neither essential nor medically necessary.[2/] She based these decisions on the wording of the policy which covers: "Charges for professional ambulance services to or from the nearest hospital where necessary care and treatment can be given." Rosa, however, determined that the Schaffer

Air Ambulance bill was covered by the policy and, therefore, paid this claim promptly.

On October 22, 1982, Los Angeles Children's Hospital mailed to Connecticut General medical bills incurred by Jonathan for emergency surgery on September 15, 1981. Similarly, other medical providers involved in this hospital stay presented their medical bills to Connecticut General within a reasonable time after they were incurred. Notwithstanding provisions in the policy booklet calling for immediate payment upon receipt of proof of loss, Connecticut General delayed payment of a majority of these medical bills for three to eleven months after presentation. Similarly, Connecticut General delayed payment for over eight months of the claims sustained by Jonathan's hospitalization at Los Angeles Children's Hospital beginning on October 16, 1981. Theodore repeatedly telephoned Rosa

who explained to him that the reason the bills had not been paid was that they had not been received. The claims file documents kept by Connecticut General, however, show that an itemized bill from Children's Hospital in the total amount of $89,840.16 was received by Connecticut General on December 29, 1981. Connecticut General paid $9,999.00 of that claim in February 1982, and $9,999.00 on March 1982. The latter part of October it paid $69,141.44 after it had received a collection agency claim in September 1982. It made a last payment of $776.00 in late October 1982, after plaintiffs had retained counsel.

Connecticut General provided no explanation or justification for the delay in the payment of the $69,141.44 incurred by Children's Hospital from October 16, 1981 to November 13, 1981. Although Rosa testified that she did not receive an

itemized bill for the $69,141.44, Connecticut General, as stated above, admits receiving the Children's Hospital bill in the sum of $89,840.16 on December 29, 1981. The balance forward on that bill was $69,141.44. Rosa explained that she thought this figure read $9,144.00, and that it already had been paid.

II. DISCUSSION

A. Federal Preemption

Connecticut General argues that the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1381, ("ERISA"), preempts all of plaintiffs' claims for relief. While under the facts of the case at hand plaintiffs initially could have sued in federal court under ERISA for benefits due and breach of fiduciary duty, they chose instead to rely solely upon state law. As explained below, plaintiffs as masters of their complaint, were free to make this

choice since their state law claims are not preempted by ERISA.

The fact that ERISA may apply to a particular dispute because the plan under scrutiny is an ERISA plan -- as is the case here -- does not by itself answer the difficult question of ERISA's effect on state law claims against an insurance company. Rather, in order to resolve this issue, it is necessary to distinguish between state laws which regulate an employee benefit plan and those which regulate an insurance company from which a plan purchases insurance. Any law directly regulating an employee benefit plan is preempted, 29 U.S.C. 1144(a), but laws regulating an insurance company or policy from an insurance company are saved from preemption. Eversole v. Metropolitan Life Insurance Co., Inc., 500 F. Supp. 1162 (C.D. CA 1980); Accord McLaughlin v. Connecticut General Life Insurance Co., 565

F. Supp. 434 (N.D. CA 1983).

Section 1144(b)(2)(A) saves from preemption state laws which "regulate insurance." The phrase "regulating the business of insurance" has been defined as "statutes aimed at protecting or regulating this relationship, directly or indirectly." See Eversole, 500 F. Supp at 1168, relying on SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969); McLaughlin, 565 F. Supp. at 443. Under the facts of the case at hand, the purpose of the state laws underlying plaintiffs' claims is to secure the insured's rights as policyholders. As a consequence, these claims should be treated as insurance regulations which are saved from preemption as was the case in Eversole and McLaughlin. This conclusion is further strengthened by § 1144(b)(2)(B), the "deemer clause." That subsection prohibits a state from deeming an employee benefit plan to be

an insurance company for the purpose of any state law regulating insurance. The effect of this clause is to prohibit a state from regulating a self-insured employee benefit plan as if it were an insurance company. Eversole, 500 F. Supp at 1169; McLaughlin, 565 F. Supp. at 443.

Russell v. Massachusetts Mutual Life Insurance Co., 722 F.2d 482 (9th Cir. 1983) does not compel a different result. In Russell the plans in question were self-funded employee benefit plans. Neither involved insurance policies. As a consequence, the savings clause of ERISA did not serve to protect the plaintiff's state law claims which were directed to the plans. In contrast, here, as in Eversole and McLaughlin, Connecticut General issued a group insurance policy to a plan. Since plaintiffs' claims are directed to this policy, the savings clause is triggered. Russell,

therefore, does not alter the rule that any law directly regulating an employee benefit plan is preempted, but laws regulating an insurance company or policy purchased from an insurance company are saved from preemption. See Eversole, 500 F. Supp. at 1170.

B. Substantive Claims

1. Coverage Under the Policy

(a) KLM Airline Ticket

Rules governing the interpretation of insurance contracts in California are well settled. First, ambiguities are construed against the insurance company. Therefore, coverage clauses are interpreted broadly in favor of coverage, while exclusions are interpreted narrowly. McLaughlin, 565 F. Supp. 434, 440 (N.D. Cal. 1983); see also State Farm Mutual Automobile Ins. Co. v. Partridge, 10 Cal.3d 94, 101-02, 109 Cal. Rptr. 811, 816 (1973). Second, if two or more interpretations are reasonable, the

court must adopt the interpretation which favors coverage. "If semantically permissible, an insurance contract will be given such interpretation as will fairly achieve its object of securing indemnity to the insured for the losses to which the insurance relates." State Farm Mutual Automobile Ins. Co. v. Jacober, 10 Cal. 3d 193, 203, 110 Cal. Rptr. 1, 7 (1973). In other words the insurer must establish that its interpretation supporting denial is the only reasonable construction of the contract. McLaughlin, 565 F. Supp. at 441. Third, the insurance contract must be considered in light of the insured's reasonable expectation of coverage. If coverage reasonably may be expected but is not to be provided, notice of noncoverage must be conspicuous, plain, and clear. Id.

Even if the ABC Trust, on behalf of its employer members, bargained for this

contract, the California rules outlined above apply to the facts of this case. See McLaughlin, 565 F. Supp. 434; Jones v. Crown Life Ins. Co., 86 Cal. App.3d 630, 150 Cal. Rptr. 375 (1978). Therefore, in order to prevail on the issue of the KLM bill, Connecticut General must show either that the clause unambiguously excludes coverage or that the clause cannot be interpreted reasonably to provide coverage. As stated above, the clause in question covers "charges for professional ambulance service to or from the nearest hospital where necessary care and treatment can be given." At various times Connecticut General contended that the claim for the KLM flight was not subject to coverage because: (1) it was a pleasure flight; (2) the services were not performed at the nearest hospital where treatment could have been provided; and (3) the treatment was not essential and

medically necessary.

The clause, however, does not specifically exclude from coverage the use of a passenger airline, does not state criteria to determine what is the nearest hospital where treatment could be received, and does not provide any guidance as to when and under what circumstances care and treatment is necessary. Furthermore, it is reasonable to interpret the clause as providing coverage for transportation upon a passenger airline to a hospital recommended by doctors for treatment which the doctors believe is essential and medically necessary. Although the doctors in San Francisco determined that Jonathan was too small and had to grow before the operation could be performed, the doctors in Holland thought that an immediate operation was necessary.

Even if the clause cannot be interpreted reasonably to provide coverage, Connecticut

General is liable for the KLM bill because it breached its contractual duty to make an adequate investigation of plaintiffs' claims. The duty to investigate possible bases for an insured's claim includes the duty to investigate grounds for denying the claim. Prior to rejecting the claim for the KLM bill, Connecticut General neither investigated whether Moffitt Hospital was the nearest hospital nor whether the treatment Jonathan was to receive there was medically necessary. For example, Connecticut General never discussed with the physicians at Moffitt Hospital or with the referring physicians in Holland the necessity of Jonathan's receiving treatment at Moffitt Hospital as opposed to a hospital in Europe. Failure to substantiate the grounds for rejection through proper investigation renders Connecticut General liable for the claim.

For either reason set forth above, Connecticut General is liable for the KLM bill. Because Hart, Shaffner & Marx has paid $698.40, its share of the KLM bill under the coordination of benefits agreement, Connecticut General is liable for 80% of the remaining sum of $2,793.60 or $2,234.88.

(b) Failure to Pay Other Claims Immediately

Page 34 of the plan booklet states: "All benefits other than disability income benefits will be paid by Connecticut General immediately upon receipt of due proof." Connecticut General breached its contract with plaintiffs by failing to comply with this term.

The evidence at trial revealed that payment on many of the other claims was delayed for over nine months. For example, the $69,141.44 issued to Children's Hospital

was not paid until Connecticut General received a collection agency claim, nine months after its receipt of the $89,840.16 bill with a balance forward of $69,141.44. Similarly, the last installment of the $89,840.16 bill in the sum of $776.00 was not paid until ten months after receipt of the bill.

Connecticut General neither has justified the delay in these payments nor has provided any rationalization for its failure to investigate in a timely fashion the status of the $69,141.40 sum. Connecticut General knew or should have known that the sum had not been paid at least as early as December 29, 1981, when it received the balance forward indication on the $89,840.16 bill. Connecticut General, therefore, breached its contract with the Kannes by failing to pay the claims "immediately upon receipt of due proof."

2. Breach of the Covenant of Good Faith and Fair Dealing

In addition to the duties imposed by the express terms of an agreement, the law in California implies in every contract a covenant of good faith and fair dealing. Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 157 Cal. Rptr. 482 (1979), cert. denied, 445 U.S. 912 (1980). This implied promise requires each contracting party to refrain from acting in any way that would impede the right of the other to receive the benefits of the agreement. Egan, 24 Cal.3d at 818, 169 Cal. Rptr. at 695.

Denial of a claim for insurance benefits where benefits were in fact due under an insurance contract is not, in and of itself, a breach of the implied covenant; an insurer is not required to pay every claim presented to it. Austero v. National Cas. Co., 84 Cal.App.3d 1, 30, 148 Cal.Rptr.

653, 672.

Instead, in order to be liable for breach of the implied covenant of good faith and fair dealing, Connecticut General must have acted unreasonably and in bad faith. Silberg v. California Life Ins. Co., 11 Cal.3d 452, 461, 113 Cal. Rptr. 711 (1974); Austero, 84 Cal. App.3d at 27, 148 Cal. Rptr. at 670. Bad faith, in this context, is an imprecise label for what essentially is some kind of unreasonable insurer conduct. Austero, 84 Cal.App.3d at 27 n.22, 148 Cal.Rptr. at 670 n.22. Thus, generally, the substance or gravamen of the wrong in first party insurance cases (as distinguished from third party insurance cases where the insurance company is being sued for refusing to accept the third party's offer to settle his claim) is an unreasonable refusal to pay benefits due under the terms of the policy. The benefit contracted for by an insured

under the terms of a policy is the availability of money promptly upon the occurrence of a particular event. When an insurer refuses unreasonably to make a payment of the benefit due, or when the insurer does not pay promptly, it deprives the insured of the essence of the bargain. The insured bargained for prompt payment, not a right of action against the insurer. Austero, 84 Cal. App.3d at 30, 148 Cal. Rptr. at 670.

The facts of this case go beyond the typical first party insurance case in that all but one of the claims presented (the KLM airline ticket) have been paid. Nonetheless, the test of liability in this case is the same -- whether Connecticut General's failure to investigate possible bases that may have supported plaintiffs' claims as well as its failure to pay these claims promptly was unreasonable.

From the evidence presented at trial, this Court has concluded that Connecticut General acted unreasonably in these respects. As stated previously, payment on several of the claims was delayed for over nine months. In addition, Connecticut General failed to investigate several of the claims, specifically, the KLM airline ticket, as well as the status of the $69,141.40 bill. Because Connecticut General acted in an unreasonable manner in handling plaintiffs' claims, Connecticut General breached the implied covenant of good faith and fair dealing.

This lawsuit could have been avoided had there been better communication between the parties. While both sides share responsibility for this breakdown in communication, most of the blame rests with Connecticut General, a sophisticated insurance company whose obligation is to process claims in a timely, efficient, and cordial manner.

People insure themselves for peace of mind and security. To protect these interests, it is essential that an insurer fully inquire into the possible bases that might support the insured's claim and act promptly. In this case, Connecticut General became overly pedantic and insensitive to plaintiffs during their time of great stress.

The Court does not find that the plaintiffs were negligent in the submission of their claims. While they may not have acted in strict conformity with the defendants' requirements, their failure to do so was reasonable under all of the circumstances. Early on, defendants were placed on notice that plaintiff's child was seriously ill, and would require extensive hospitalization and treatment. Repeated requests for payment of the bills were made to the claims representative, and copies of the bills were in defendants' possession. Under these

circumstances, it is not proper for the insurer to sit back and delay payment of the claims, under the pretextual theory that the plaintiffs have not dotted all the "I's" and crossed all the "T's". On the contrary, the insurer has the duty to take the initiative to see to it that the promised protection is delivered when needed. It must act to facilitate the claims instead of searching for reasons not to do so.

3. Breach of Fiduciary Duty

Plaintiffs argue that Connecticut General breached its fiduciary duties in its dealings with them. California law, however, does not recognize an action for breach of fiduciary duty between an insurer and an insured.

An insurance policy is a contract. As such, there is implied within every insurance policy a duty of good faith and fair

dealing. While this duty is fiduciary in nature, it does not create a fiduciary relationship. See, Spindle v. Chubb/Pacific Indemnity Group, 89 Cal. App.3d 706, 712, 152 Cal.Rptr. 776, 780 (1979).

In the insurance context, the implied covenant of good faith and fair dealing requires no more than "that each party is prevented from interfering with the other's right to benefit from the contract." Miller v. Elite Ins. Co., 100 Cal. App.3d 739, 756, 161 Cal. Rptr. 322, 331 (1980). It does not further require that the insurer place the insured's interests above its own as would be the case were the insured a fiduciary. The Miller court also noted that "where a conflict of interest emerges, the carrier has the obligation of protecting the interests of the insured [only] equally with his own." Miller, 100 Cal. App.3d at 756; 161 Cal. Rptr. at 331; see also, Egan

v. Mutual of Omaha Ins. Co., 24 Cal.3d at 818; 169 Cal. Rptr. at 695 (1979); Silberg, 11 Cal.3d at 460, 113 Cal. Rptr. at 717.

An insurance company, moreover, is privileged, in pursuing its own economic interests, to assert its legal rights. Fletcher v. Western National Life Insurance Co., 10 Cal. App.3d 376; 89 Cal. Rptr. 78 (1970).

> [A]n insurer is not required to pay every claim presented to it. Besides the duty to deal fairly with the insured, the insurer also has a duty to its other policyholders and to the stockholders (if it is such a company) not to dissipate its reserves through payment of meritless claims. Such a practice inevitably would prejudice the insurance seeking public because of the necessity to increase rates, and would finally drive the insurer out of business.
>
> Austero, 84 Cal. App.3d at 30, 148 Cal. Rptr. at 672.

Finally, as stated in McLaughlin:

> it strains credulity to suggest, as defendant does here, that when

> an insurance company is the fiduciary [under ERISA] making claims decisions under a group policy, that it is due the same deference accorded to trustees who have no financial interest in their decisions. There is an inherent conflict of interest between an insurance company's duties to plan participants and to its policyholders. To remedy this conflict, California insurance law holds insurers to fiduciary standards by inter alia applying strict rules of construction against the insurer. McLaughlin, 565 F.Supp at 447 n.9.

In this case this Court has applied strict rules of construction against Connecticut General in order to remedy the inherent conflict of interest between its duties to its plan participants and its duties to its policyholders. Even were Connecticut General a fiduciary under ERISA, it would not be a fiduciary under California law. Under that law, while Connecticut General is obliged to act in good faith and deal fairly, this is not a fiduciary duty.

4. Fraud

Plaintiffs' complaint alleges a cause of action for fraud based upon Connecticut General's alleged promises to them which plaintiffs claim were made without intent to perform. Specifically, plaintiffs contend that the policy contained promises that any expenses incurred by reason of Jonathan's medical problems, including his air fare from Holland to Los Angeles, would be covered in full by coordination of benefits between the various insurance companies insuring plaintiffs. Plaintiffs further contend that they were induced by these promises to purchase a policy, and also relied upon the representation to refrain from procuring other insurance.

In order to prevail on their fraud claim, plaintiffs needed to show misrepresentation, knowledge of falsity, intent to defraud -- that is, intent to induce

reliance -- justifiable reliance, and resulting damage. 4 Witkin, Summary of California Law Torts § 466 at 2711 (8th ed. 1974). The evidence at trial fails to support each of these elements. Connecticut General did not make any false representations that any medical expenses resulting from illness to Jonathan would be covered by the policy and paid promptly. The liability in this case stems from Connecticut General's failure to comply with their own internal regulations rather than from Connecticut General's intent to defraud.

5. Breach of the Statutory Duties Imposed by Insurance Code Section 790.03(h)

Plaintiffs assert that Connecticut General violated §§ 790.03(h)(2) and 790.03 (h)(3) of the Claifornia Insurance Code. These sections prohibit respectively, the failure "to acknowledge and act

reasonably promptly upon communications with respect to claims arising under insurance policies [,]" and the failure "to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies."

Connecticut General violated § 790.03(h)(2) by failing to acknowledge and act reasonably promptly upon the Kanne's claims, notwithstanding Theodore's repeated efforts to obtain payment. Theodore's many telephone calls to Connecticut General were unproductive. Eventually, he became so frustrated that following Jonathan's release from the hospital in February 1982, Theodore went to see Rosa. Although he presented to her, on that occasion, a number of the unpaid bills, which did not include the Children's Hospital bill in the sum of $69,141.40, several of these bills remained unpaid for many months thereafter.

Connecticut General, however, did not violate § 790.03(h)(3). Mr. Hanna, the Complex Manager at Connecticut General testified that Connecticut General has adopted and implemented standards for the prompt, accurate, and courteous investigation and processing of claims of policyholders. These standards are reasonable. Thus, although Rosa did not comply with these standards in handling the Kanne's claims, Connecticut General did not violate § 790.03(h)(3).

C. Exemplary And Other Damages

Were plaintiffs to have prevailed on their breach of contract claim alone, they would be entitled only to the award of compensatory damages set forth above for the KLM ticket. Civil Code § 3294 provides:

> In an action for the breach of an obligation not arising from contract, where the defendant has been guilty of oppression, fraud, or malice, express or implied, the

> plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing the defendant.

Punitive damages thus are not available in an action based solely upon breach of a contractual obligation, even where the breach is intentional, willful, or in bad faith. However, where an action also sounds in tort, exemplary damages may be recovered upon proper showing of malice, fraud or oppression, even though the tort incidentally involves a breach of contract. Miller v. National American Life Insurance Co. of California, 54 Cal.App.3d 331, 336, 126 Cal. Rptr. 731, 733 (1976).

Plaintiffs, therefore, may be entitled to punitive damages on the tort theory on which they have prevailed, breach of the implied covenant of good faith and fair dealing. The mere fact that an insurer has breached its duty of good faith and fair

dealing by acting unreasonably in handling a claim, however, does not mean that the insurance company automatically is liable for exemplary damages. Austero, 84 Cal. App.3d at 36, 148 Cal. Rptr. at 676; Silberg, 11 Cal.3d at 462, 113 Cal. Rptr. at 718. Exemplary damages may be awarded only where there is oppression, fraud, malice to vex, annoy or injure, or where there is a conscious disregard of a plaintiff's rights. Miller v. Elite Insurance Co., 100 Cal. App.3d 759, 161 Cal. Rptr. 322 (1980). Thus, to be liable for punitive damages on a breach of good faith and fair dealing claim an insurer must have acted with actual malice which may be inferred from the circumstances of the case. Miller, 100 Cal. App.3d at 758, 161 Cal. Rptr. at 333, (citing Richardson v. Employer's Liability Assurance Corp., 25 Cal. App.3d 232, 245; 102 Cal. Rptr. 547, 556

(1972)); See also BAJI 6.94 and 14.71.

The evidence presented at trial established that Connecticut General acted with actual malice towards the Kannes. Connecticut General consciously disregarded the Kannes' rights by failing to process their claims in a prompt manner, by failing to investigate their claims, and by interpreting some of their claims in an unreasonable manner.

Connecticut General's breach of the implied covenant of good faith and fair dealing, and violation of Insurance Code §790.03(h)(2) were the proximate and direct cause of all loss, damage, emotional distress, embarrassment and fear of denial of medical treatment suffered by plaintiffs. Plaintiffs have suffered emotional distress, humiliation and embarrassment to their damage in the sum of $ 250,000.00 . In addition, plaintiffs are entitled to exemplary damages in the sum of $500,000.00, an amount

which the Court believes is sufficient to deter Connecticut General and other such insurance companies from treating their policyholders and insureds in the manner in which the Kanne's have been treated.

D. ATTORNEY'S FEES

In the prayer of the complaint, plaintiffs seek to recover attorney's fees as an element of damages. In California, in the absence of an attorney's fee clause in the applicable insurance policy, attorney's fees are not recoverable in a bad faith action against an insurance company. Moore v. American United Life Insurance Co., 150 Cal. App.3d 610, 644; 197 Cal. Rptr. 878, 900 (1984). The question, therefore, becomes whether or not there is an attorney's fee provision in the insurance contract between the Kannes and Connecticut General. The policy provides in pertinent part:

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

> If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area office of the U.S. Labor - Management Services Administration, Department of Labor.

This summary plan description is meant to provide policyholders with an understanding of their rights under ERISA such as those set forth in 29 U.S.C.§1132(g). That section states that: "In any action under this subchapter by a participant, beneficiary, or fiduciary, the court on its discretion may allow a reasonable attorney's fee and costs of action to either party."

Thus, although the summary plan description does not expressly restrict the Court's discretion to award attorney's fees to actions brought under ERISA, the description should be interpreted in this fashion. As

a consequence, since the Kannes chose to proceed only under state law, the Court has no power to award them attorney's fees in this action. They are, however, entitled to their costs.

LET JUDGMENT BE ENTERED ACCORDINGLY.

DATED: January 23 1985.

/s/
EDWARD RAFEEDIE
United States District Judge

FOOTNOTES

1. Although Beatriz was not covered as an eligible employee under the policy, Beatriz as Theodore's spouse is a party to the insurance contract and, therefore, has standing to sue for the claims asserted. The policy booklet states at page 4 that "you and your family members are eligible to participate in this plan . . ." and further defines family members as one's spouse. Under the policy, therefore, Beatriz is able to recover expenses incurred on behalf of a dependent to the same extent as Theodore. Moreover, it is reasonably foreseeable that Beatriz, in addition to Theodore, could suffer emotional distress from Connecticut General's improper handling of the Kanne family's claims.

2. In addition, she, at one time, told Theodore that the flight was not covered

because it was a "pleasure trip."

cf. McLaughlin v. Connecticut General, 565 F. Supp. 434, 453 (N.D. CA 1983) holding that both Mr. and Mrs. McLaughlin were parties to the insurance contract, he as the "employee" and she as his "dependent" and thus both had standing to seek damages for emotional distress and other injuries for breach of the implied covenant.

APPENDIX B

APPENDIX B

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant/Appellant,

LINCOLN NATIONAL LIFE INSURANCE COMPANY and HARLOW CARPETS, INC.,

Defendants.

No. 85-5641

D.C. No. CV 83-2261-ER

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellants,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No. 85-5642

OPINION

Argued and Submitted
April 7, 1986-Pasadena, California
Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

Appeal from the United States District Court for the Central District of California Edward Rafeedie, District Judge, Presiding

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SUMMARY

Insurance

Appeal from judgment. Reversed.

This action arises from appellant Connecticut General's obligation to pay the costs for appellees' (the Kannes) son. The Kannes prevailed on two state common-law causes of action: breach of contract and breach of duty of good faith and fair dealing, and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.

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*Honorable Philip C. Wilkins, Senior United States District Judge, Eastern District of California, sitting by designation.

Connecticut General contends that these state-law claims are preempted by the Employee Retirement Income Security Act (ERISA).

[1] The Supreme Court has held that state common law causes of action asserting improper processing of a claim are preempted by federal law. [2] Reading two recent Supreme Court decisions together compels this court to conclude that the Kannes' claim that transportation costs are reimbursable under the insurance policy is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

OPINION

PER CURIAM:

Appellant Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding the Kannes $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorneys fees.

The Kannes brought this action, which arises out of Connecticut General's obligation to pay the costs of medical treatment for their son, Jonathan, for reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and for compensation for the

emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories. They prevailed on three that are at issue on appeal: two state common-law causes of action, one for breach of contract and the other for breach of duty of good faith and fair dealing, and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

DISCUSSION

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedaux, No. 85-1043 (U.S. Apr. 6, 1987), in light of

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[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims, see Cal.Ins.Code § 790.03(h)(3). They do not appeal the denial of those claims.

Connecticut General's contention at trial and before this court that the Kannes's state-law claims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 et seq.[2] Pilot Life and a companion case, Metropolitan Life Insurance Co. v. Taylor, No. 85-686 (U.S. April 6, 1987), which also bears on the issues presented here, have now been

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[2]ERISA's relationship to state laws is governed by § 1144 of the Act. The pertinent subsections of § 1144 provide:

> (a) Except as provided in subsection (b) of this section, the provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
>
> (b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States....

decided. We now resubmit the case and review de novo as a matter of law the district court's conclusion that the claims were not preempted. United States v. McConney, 728 F.2d 1195 (9th Cir.) (en banc), cert. denied, 469 U.S. 824 (1984). We reverse.

[1] In Pilot Life, the Supreme Court held that state common law causes of action asserting improper processing of a claim are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the claims of delay in payment must be vacated.

[2] Reading of Pilot Life, together with Metropolitan Life, compels us to conclude that the Kannes' claim that transportation costs are reimbursable under the

insurance policy is also preempted. Because the claim "relate[s] to an employee benefit plan," see Metropolitan Life, slip op. at 4 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). California's common law of contract interpretation is not "specifically directed toward [the insurance] industry." See Pilot Life, slip op. at 8; see also Metropolitan Life, slip op. at 4. Nor generally does it effect risk spreading or concern the policy relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Id. at 9. Accordingly, we conclude that California's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[3] The district

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[3] See p.B-52.

court's judgment based on the Kannes' claim for transportation costs must also be vacated.[4]

CONCLUSION

We resubmit this case for decision. We reverse the district court's compensatory and punitive damage awards in favor of the Kannes. We affirm the denial of attorneys fees to the Kannes.

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[3]Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[4]Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal.Rptr. 211, 214 (1985). The general rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX C

APPENDIX C

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellant,

LINCOLN NATIONAL LIFE INSURANCE COMPANY and HARLOW CARPETS, INC.,

Defendants.

No.85-5641

D.C.No. CV 83-2261-ER

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellants,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No.85-5642

OPINION

Appeal from the United States District Court for the Central District of California
Edward Rafeedie, District Judge, Presiding

Argued and Submitted April 7, 1986
Pasadena, California

Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Petition for Rehearing granted and opinion withdrawn from submission July 23, 1987

Argued and Resubmitted November 23, 1987

Filed October 4, 1988

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

SUMMARY

Insurance

Vacating a judgment, the court found an insurance policy governed and preempted by ERISA.

Appellant Connecticut General Life Insurance Co. appeals from a judgment awarding appellees Theodore and Beatriz Kanne compensatory and punitive damages. The Kannes cross-appeal the denial of attorney's fees. The

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*Hon. Philip C. Wilkins, Senior United States District Judge for the Eastern District of California, sitting by designation.

action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the U.S. for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The court considers two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. This court now concludes both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

[1] Recently, it was found that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan. [2] The plan brochure submitted by Connecticut

General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. The ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. [3] The Kannes and numerous amici argue that section 790.03(h) is not preempted by ERISA because the section is a law regulating insurance within the meaning of the so-called "savings clause" of ERISA. [4] To accept the Kannes' argument asking this court to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause, would have this court ignoring the second half of Pilot Life. The Supreme Court made clear that its preemption holding was equally

based on its acceptance of the Solicitor General's view that Congress clearly expressed an intent that the civil enforcement provisions of ERISA section 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

OPINION

PER CURIAM:

Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding Theodore and Beatriz Kanne $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorneys fees.

This action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories and prevailed on three causes that are at issue on appeal: two state common-law causes of action (breach

of contract, and breach of the duty of good faith and fair dealing) and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedaux, 107 S. Ct. 1549 (1987), in the expectation that Pilot Life would resolve the threshold issue of whether the Kannes' state-law claims are preempted by the Employee Retirement Income Security Act of 1974) (ERISA), 29 U.S.C. §§1001 et seq.[2] After

[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims. See Cal. Ins. Code § 790.03(h)(3). They do not appeal the denial of those claims.

[2]ERISA's relationship to state laws is governed by § 514 of the Act, 29 U.S.C. § 1144. The pertinent subsections of §514 provide:

> (a) Except as provided in subsection (b) of this section, the

(con't p. C-60)

Pilot Life and a companion case, Metropolitan Life Insurance Co. v. Taylor, 107 S.Ct. 1542 (1987), were decided, we resubmitted the case and reversed the district court's conclusion that the claims were not preempted. Kanne v. Connecticut General Life Ins. Co., Nos. 85-5641, 85-5642 (9th Cir., June 4, 1987).

We subsequently withdrew the opinion, granting the Kanne's request for rehearing, to consider two specific issues: (1) whether the insurance policy in question is a plan

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2 (con't)

> provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
>
> (b)(2)(A) Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States....

governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. We now conclude both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

DISCUSSION

I. Whether the Insurance Policy is part of an ERISA Plan

The parties at trial apparently assumed that the insurance policy was covered by ERISA. Little or no attention was paid to the issue. The plan brochure, introduced by Connecticut General as an exhibit at trial, describes the plan as an ERISA plan. The Associated Builders and Contractors (ABC), an employer group to which Harlow Carpets belongs, is described as the Administrator of the plan. Harlow Carpets subscribed to the group health insurance plan

administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General.[3] Theodore Kanne was an employee of Harlow Carpets and was covered by the policy.

Under ERISA § 3(1), 29 U.S.C. § 1002(1), an "employee welfare benefit plan" or "Welfare plan" is:

> (1) a "plan, fund or program"
> (2) established or maintained
> (3) by an employer or by an employee organization, or by both,
> (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to the participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982)(en banc).

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[3]Prior to 1981, Harlow Carpets had subscribed to an insurance plan directly with Connecticut General, but then changed to the ABC plan.

[1] The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person. Credit Managers Ass'n v. Kernesan Life & Accident Ins. Co., 809 F.2d 617, 625 (9th Cir. 1987). At trial, the parties did not contest the issue of whether the ABC Trust was an ERISA plan. However, in the wake of the broad holding of Pilot Life, that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan, the question of whether the policy here is governed by ERISA takes on vital importance to the Kannes, who now contest that an ERISA plan existed.

The Department of Labor has issued regulations excluding certain group insurance programs from ERISA's definition of "Employee welfare benefit plan":

(j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j)(1987). A bare purchase of insurance, without any of the above

elements present, does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan). See Donovan v. Dillingham, 688 F.2d at 1375. An employer has not established an ERISA plan if it merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). See Credit Managers Ass'n., 809 F.2d at 625.

The Kannes argue that, in respect to the group insurance at issue here, there is no evidence of the existence of the four criteria under 29 C.F.R. § 2510.3-1(j), any one of which would prevent the exclusion of the insurance plan from ERISA coverage.[4] It is true that the record is ambiguous as to whether Harlow Carpets ever contributed

[4]Because Connecticut General's claim of ERISA preemption is a federal defense in this lawsuit, Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. at 1546, the burden is on the defendant to prove the facts necessary to establish it.

any payments towards Theodore Kanne's insurance coverage or whether Kanne's participation was voluntary or automatic. Harlow Carpets' function with respect to the program was minor and ministerial, and no evidence indicates whether the plan was administered by a profit-making concern.

However, the problem with the Kannes' argument is their apparent assumption that Harlow Carpets' functions with respect to the plan determine ERISA coverage. According to ERISA § 3(5):

> The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5)(emphasis added). Under this definition, ABC can be an ERISA employer for purposes of our analysis.

[2] The plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. It is clear that, at a minimum, ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, "endorses" it within the meaning of 29 C.F.R. § 2510.3-1(j)(3). Thus the ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. See Credit Managers Ass'n, 809 F.2d at 625.

II. Whether ERISA Preempts the Kannes' State Law Claims

In Pilot Life, the Supreme Court held that state common law causes of action arising from the improper processing of a claim

are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the common law claims for delay in payment must be vacated.

We must also decide whether ERISA preempts the Kannes' state statutory claims for compensatory and punitive damages arising from delay in payment. California Insurance Code § 790.03(h) prohibits various "unfair insurance practices" having to do with the processing of claims. Among these unfair practices is an insurer's failure "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." §790.03(h)(2). At the time relevant to this appeal § 790.03(h) created a private right of action. Royal Globe Ins. Co. v.

Superior Court, 23 Cal.3d 880, 886, 153 Cal. Rptr. 842, 846 (1979), overruled by Moradi-Shalal v. Fireman's Fund Ins. Co., ___ Cal. 3d ___ (Cal. Aug. 18, 1988).[5] The district court found that Connecticut General had violated subsection (h)(2), giving rise to a cause of action in the Kannes.

[3] The Kannes and numerous amici argue virorously that § 790.03(h) is not pre-empted by ERISA because § 790.03(h) is a law regulating insurance within the meaning of the so-called "savings clause," § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

[5]The Moradi-Shalal court held that the Royal Globe rule would continue to apply to all cases filed prior to the Moradi-Shalal decision. ___ Cal.3d at ___.

The Kannes and the amici point out that the preempted common law causes of action for bad faith in Pilot Life were held not to be laws regulating insurance within the savings clause. They argue that because § 790.03(h) regulates insurance, the savings clause saves that provision from preemption. We can assume, without deciding, that § 790.03 (h) is a law regulating insurance under the savings clause. Noevertheless, under Pilot Life we find the conclusion inescapable that § 790.03(h) is preempted by ERISA.[6]

[4] The Kannes' argument asks us to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause. To accept this argument,

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[6]A handful of cases in federal district courts in California have by now been decided, reaching differing results. We find ourselves most in agreement with the well-reasoned opinion in Roberson v. Equitable Life Assurance Soc., 661 F.Supp. 416, 423-24 (C.D. Cal. 1987).

however, we would have to ignore the second half of Pilot Life, 107 S.Ct. 1555-58, in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." Id. at 1555. The Court stated:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress had rejected in ERISA.

Id. at 1556. We do not find it possible to read this language in a way that permits a state statute like § 790.03(h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing. Accordingly, the Kannes state statutory cause of action for mishandling of their insurance claim is also preempted.

Finally,we must consider whether the Kannes' claim for reimbursement of transportation costs is preempted. Because the claim "relate[s] to an employee benefit plan," see Metropolitan Life, 107 S.Ct. at 1546 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The Kannes' claim for reimbursement is premised on the interpretation of their insurance contract. However, California's common law of contract interpretation is not

"specifically directed toward [the insurance] industry." See Pilot Life, 107 S.Ct. at 1555; see also Metropolitan Life, 107 S.Ct. at 1546. Nor generally does it effect risk spreading or concern the policy relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Pilot Life, 107 S.Ct. at 1554-55. Accordingly, we conclude that Californaia's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[7] The district court's judgment based on the Kannes' claim for transportation costs must also be vacated.[8]

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[7] Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[8] Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

(cont. p. C-74)

CONCLUSION

We find that the Kannes' group health insurance policy with Connecticut General is part of an ERISA plan. We hold that each of their state common-law and statutory causes of action is preempted by ERISA. Accordingly, we VACATE the judgment of the district court insofar as it awards damages in favor of the plaintiffs.

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[8](cont.)

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal. Rptr. 211, 214 (1985). The general rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX D

APPENDIX D

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellant,

LINCOLN NATIONAL LIFE INSURANCE COMPANY and HARLOW CARPETS, INC.,

Defendants.

No.85-5641

D.C.No. CV83-2261-ER

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellants,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No.85-5642

ORDER AND AMENDED OPINION

Appeal from the United States District Court for the Central District of California
Edward Rafeedie, District Judge, Presiding

Argued and Submitted
April 7, 1986--Pasadena, California

Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Petition for Rehearing granted and opinion withdrawn from submission July 23, 1987

Argued and Resubmitted November 23, 1987

Filed October 4, 1988
Amended February 2, 1989

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

SUMMARY

Insurance

Vacating a judgment, the court found an insurance policy governed and preempted by ERISA.

Appellant Connecticut General Life Insurance Co. appeals from a judgment awarding appellees Theodore and Beatriz Kanne compensatory and punitive damages. The Kannes

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*Hon. Philip C. Wilkins, Senior United States District Judge for the Eastern District of California, sitting by designation.

cross-appeal the denial of attorney's fees. The action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the U.S. for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The court considers two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. This court now concludes both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

[1] Recently, it was found that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan. [2] The

plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. The ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. [3] The Kannes and numerous amici argue that section 790.03(h) is not preempted by ERISA because the section is a law regulating insurance within the meaning of the so-called "savings clause" of ERISA. [4] To accept the Kannes' argument asking this court to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause, would have this court ignoring the second half of Pilot Life. The Supreme Court made clear

that its preemption holding was equally based on its acceptance of the Solicitor General's view that Congress clearly expressed an intent that the civil enforcement provisions of ERISA section 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

ORDER

We hereby amend the opinion Filed October 4, 1988.

In the middle paragraph of slip opinion at page 12500, the final sentence is changed to read:

> Nevertheless, under Pilot Life we find the conclusion inescapable that the private right of action for violation of §790.03(h) is preempted by ERISA.

Footnote 6 is amended by adding the sentence:

> We express no opinion as to whether the substantive provisions of § 790.03(h) are themselves pre-empted so as to bar administrative enforcement by California's Insurance Commissioner.

With this amendment, the panel has voted to deny the petition for rehearing. The full court has been advised of the amendment to the opinion and the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the

matter en banc. (Fed. R. App. P. 35.)

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

OPINION

PER CURIAM:

Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding Theodore and Beatriz Kanne $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorney's fees.

This action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and compensation for the emotional distress caused them by the delay in

payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories and prevailed on three causes that are at issue on appeal: two state common-law causes of action (breach of contract, and breach of the duty of good faith and fair dealing) and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedeaux, 107 S.Ct. 1549 (1987), in the expectation that Pilot Life would resolve the threshold issue of whether the Kannes' state-law claims are preempted by the Employee

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[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims. See Cal.Ins.Code § 790.03(h)(3). The do not appeal the denial of those claims.

Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq.[2] After Pilot Life and a companion case, Metropolitan Life Insurance co. v. Taylor, 107 S.Ct. 1542 (1987), were decided, we resubmitted the case and reversed the district court's conclusion that the claims were not preempted. Kanne v. Connecticut General Life

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[2]ERISA's relationship to state laws is governed by § 514 of the Act, 29 U.S.C. § 1144. The pertinent subsections of § 514 provide:

> (a) Except as provided in subsection (b) of this section, the provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
>
> (b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States....

Ins. Co., Nos. 85-5641, 85-5642 (9th Cir. June 4, 1987).

We subsequently withdrew the opinion, granting the Kannes' request for rehearing, to consider two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal.Ins. Code § 790.03(h)(2) is preempted by ERISA. We now conclude both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

DISCUSSION

I. Whether the Insurance Policy is Part of an ERISA Plan

The parties at trial apparently assumed that the insurance policy was covered by ERISA. Little or no attention was paid to the issue. The plan brochure, introduced by Connecticut General as an exhibit at

trial, describes the plan as an ERISA plan. The Associated Builders and Contractors (ABC), an employer group to which Harlow Carpets belongs, is described as the Administrator of the plan. Harlow Carpets subscribed to the group health insurance plan administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General.[3] Theodore Kanne was an employee of Harlow Carpets and was covered by the policy.

Under ERISA § 3(1), 29 U.S.C. § 1002(1), an "employee welfare benefit plan" or "welfare plan" is:

> (1) a "plan, fund or program"
> (2) established or maintained
> (3) by an employer or by an

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[3]Prior to 1981, Harlow Carpets had subscribed to an insurance plan directly with Connecticut General, but then changed to the ABC plan.

> employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to the participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982)(en banc).

[1] The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person. Credit Managers Ass'n v. Kernesan Life & Accident Ins. Co., 809 F.2d 617, 625 (9th Cir. 1987). At trial, the parties did not contest the issue of whether the ABC Trust was an ERISA plan. However, in the wake of the broad holding of Pilot Life, that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee

benefit plan, the question of whether the policy here is governed by ERISA takes on vital importance to the Kannes, who now contest that an ERISA plan existed.

The Department of Labor has issued regulations excluding certain group insurance programs from ERISA's definition of "employee welfare benefit plan":

> (j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs

> and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29C.F.R. § 2510.3-1(j)(1987). A bare purchase of insurance, without any of the above elements present, does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan). See Donovan v. Dillingham, 688 F.2d at 1375. An employer has not established and ERISA plan if it merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). See Credit Managers Ass'n, 809 F.2d at 625.

The Kannes argue that, in respect to the group insurance at issue here, there is no evidence of the existence of the four

criteria under 29 C.F.R. § 2510.3-1(j), any one of which would prevent the exclusion of the insurance plan from ERISA coverage.[4] It is true that the record is ambiguous as to whether Harlow Carpets ever contributed any payments towards Theodore Kanne's insurance coverage or whether Kanne's participation was voluntary or automatic. Harlow Carpets' function with respect to the program was minor and ministerial, and no evidence indicates whether the plan was administered by a profit-making concern.

However, the problem with the Kannes' argument is their apparent assumption that Harlow Carpets' functions with respect to the plan determine ERISA coverage. According to ERISA § 3(5):

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[4]Because Connecticut General's claim of ERISA preemption is a federal defense in this lawsuit, Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. at 1546, the burden is on the defendant to prove the facts necessary to establish it.

> The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5)(emphasis added). Under this definition, ABC can be an ERISA employer for purposes of our analysis.

[2] The plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. It is clear that, at a minimum, ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, "endorses" it within the meaning of 29 C.F.R. § 2510.3-1(j)(3). Thus the ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need

not be employer contributions or automatic employee coverage to bring the plan within ERISA. See Credit Managers Ass'n, 809 F.2d at 625

II. Whether ERISA Preempts the Kannes' State Law Claims

In Pilot Life, the Supreme court held that state common law causes of action arising from the improper processing of a claim are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the common law claims for delay in payment must be vacated.

We must also decide whether ERISA preempts the kannes' state statutory claims for compensatory and punitive damages arising

from delay in payment. California Insurance Code § 790.03(h) prohibits various "unfair insurance practices" having to do with the processing of claims. Among these unfair practices is an insurer's failure "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." §790.03(h)(2). At the time relevant to this appeal §790.03 (h) created a private right of action. Royal Globe Ins. Co. v. Superior Court, 23 Cal.3d 880, 886, 153 Cal. Rptr. 842, 846 (1979), overruled by Moradi-Shalal v. Fireman's Fund Ins. Co., ___ Cal.3d ___ (Cal. Aug. 18, 1988).[5] The district court found that Connecticut General had violated subsection (h)(2), giving rise to a cause of action in the Kannes.

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[5]The Moradi-Shalal court held that the Royal Globe rule would continue to apply to all cases filed prior to the Moradi-Shalal decision. ___ Cal.3d at ___.

[3] The Kannes and numerous amici argue vigorously that § 790.03(h) is not preempted by ERISA because § 790.03(h) is a law regulating insurance within the meaning of the so-called "savings clause," § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which provides

> Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

The Kannes and the amici point out that the preempted common law causes of action for bad faith in Pilot Life were held not to be laws regulating insurance within the savings clause. They argue that because § 790.03(h) regulates insurance, the savings clause saves that provision from preemption. We can assume, without deciding, that § 790.03(h) is a law regulating insurance under the savings clause. Nevertheless,

under Pilot Life we find the conclusion inescapable that the private right of action for violation of § 790.03(h) is preempted by ERISA.[6]

[4] The Kannes' argument asks us to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause. To accept this argument however, we would have to ignore the second half of Pilot Life, 107 S.Ct. 1555-58, in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that "Congress clearly

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[6]A handful of cases in federal district courts in California have by now been decided, reaching different results. We find ourselves most in agreement with the well-reasoned opinion in Roberson v. Equitable Life Assurance Soc., 661 F.Supp. 416, 423-24 (C.D.Cal. 1987). We express no opinion as to whether the substantive provisions of §790.03(h) are themselves preempted so as to bar administrative enforcement by California's Insurance Commissioner.

expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." Id. at 1555. The Court stated:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress had rejected in ERISA.

Id. at 1556. We do not find it possible to read this language in a way that permits a state statute like § 790.03(h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing.

Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

Finally, we must consider whether the Kannes' claim for reimbursement of transportation costs is preempted. Because the claim "relate[s] to an employee benefit plan." see Metropolitan Life, 107 S.Ct. at 1546 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The Kannes' claim for reimbursement is premised on the interpretation of their insurance contract. However, California's common law of contract interpretation is not "specifically directed toward [the insurance] industry." See Pilot Life, 107 S.Ct. at 1555; see also Metropolitan Life, 107 S.Ct. at 1546. Nor generally does it effect risk spreading or concern the policy

relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Pilot Life, 107 S.Ct. at 1554-55. Accordingly, we conclude that California's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[7] The district court's judgment based on the Kannes' claim for transportation costs must also be vacated.[8]

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[7]Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[8]Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal.Rptr. 211, 214 (1985). The general

(cont. p. D-98)

CONCLUSION

We find that the Kannes' group health insurance policy with Connecticut General is part of an ERISA plan. We hold that each of their state common-law and statutory causes of action is preempted by ERISA. Accordingly, we VACATE the judgment of the district court insofar as it awards damages in favor of the plaintiffs.

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8 (cont.)

rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX E

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29 U.S.C. Section 1144(b)(2)(A) provides:

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

29 U.S.C. Section 1003(a) provides:

"(a) Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained--

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees

engaged in commerce or in any industry or activity affecting commerce; or

(3) by both."

29 U.S.C. Section 1002(5) provides,

"For Purposes of this subchapter":

. . .

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. Section 1131 provides:

"Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than $5,000 or

imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding $100,000."

Department of Labor Regulation 29 CFR Section 2510.3-1(j) provides:

"(j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) The Participation in the program is competely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs."

California Insurance Code Section 790.03(h)(2) provides:

"The following are hereby defined as

unfair methods of competition and unfair and deceptive acts of practices in the business of insurance.

. . .

(h) Knowingly committing or performing with such frequeny as to indicate a general business practice any of the following unfair claims settlement practices:

. . .

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.